WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

10600

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred:
Allegany Hospital, Cumberland, Maryland

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1009 Lexington Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Mrs. Maxine Abe

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Mr. Charles Abe

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 14th, 1920

8. AGE: Years	Months	Days	If less than one day
25	7	24	..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Carl Furstenburg

13. Birthplace: Md.

MOTHER 14. Maiden name: Dora Sharp.

15. Birthplace: W. Va.

16. Informant: Chas. Abe.

Address: 1009 Lexington ave. Cumberland Md.

17. Burial (Burial, cremation, or removal (What?)) Date thereof: Nov. 10, 1945 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Cumberland Md.

18. Funeral director: Tasis Sheir Inc.

Address: Cumberland Md.

19. Nov. 10 1945 (Date rec'd by registrar) Hunter A. Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/8 1945, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1942 to Nov 8 1945

and that I last saw h... alive on Nov 7 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Ch. Myelogenous leukemia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F. G. Ombrd M. D. or other

Address: Medical Bldg. Date signed: Nov 8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

10601

CERTIFICATE OF DEATH

Reg. Dist. No. 4-7

1. PLACE OF DEATH:

County Allegany

City or town Near Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month.

Hospital, institution, or street address where death occurred:

Star Route – Flintstone

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 159 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Rose Kathleen Belfoure

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Michael Belfoure

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) May 11, 1913

8. AGE: Years 32 Months 6 Days 9 If less than one day hrs. min.

9. Birthplace Beverly Randolph Co. W. Va. Cumberland Allegany Co. Md (Town, county and state)

10. Usual occupation House work

11. Industry or business At Home

FATHER 12. Name James R. Canfield

13. Birthplace Elkins W. Va.

MOTHER 14. Maiden name Melissa A. Bright

15. Birthplace Parsons W. Va

16. Informant James R. Canfield Jr.

Address 224 N. Lee St Cumb, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 23, 1945 (month) (day) (year)

Cemetery or crematory Canfield Cemetery

Location Near Elkins W. Va.

18. Funeral director John J. Yaden

Address Cumberland Md.

19. Nov 23, 1945 (Date rec'd by registrar) Nimrod L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1945 at 6:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pierce H. Bowen M.D. M. D. or other

Address Cumberland, Maryland Date signed 11-21-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-e)

CERTIFICATE OF DEATH

10602

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 3 Days 5 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Oldtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Jobe Bible

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Iva Bible

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 30 1871

8. AGE: Years	Months	Days	If less than one day
74	7	27	..... hrs. ..... min.

9. Birthplace: Franklin, Pendleton Co, W. Va. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER — 12. Name: James W. Bible

FATHER — 13. Birthplace: Franklin, W. Va.

MOTHER — 14. Maiden name: Isabelle Millison

MOTHER — 15. Birthplace: Franklin, W. Va.

16. Informant: Russell Bible

Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/30/45 (month) (day) (year)

Cemetery or crematory: Ft. Ashby Cemetery

Location: Fort Ashby, W. Va.

18. Funeral director: William H. Light

Address: Cumberland, Md.

19. Nov 29 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: November 27th., 1945 at 10.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death: Shock; probably internal injuries. — DURATION: 3 days, 4 hrs., 50 min.

Due to: .....

Due to: .....

Other conditions: fract. right leg, upper third.

(Include pregnancy within 3 months of death)

Major findings of operations: fract. reduced — Date of op. .....

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: under investigation Date of 11-24-45

Where did injury occur? near Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury: struck by car Injured at work? no

23. SIGNATURE: Pierce H. Johnson, M.D.

Address: Cumberland, Maryland. M. D. or other

Date signed: 11-28-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

10603

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7. Years

Hospital, Institution, or street address where death occurred:
133. Potomac St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 133. Potomac St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Laura Boone

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W. Boone

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): August 12, 1914

8. AGE: Years	Months	Days	If less than one day
31	3	14	..... hrs. ..... min.

9. Birthplace: Onega, Pendleton Co, West Virgina
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: Columbus Long
13. Birthplace: Onega, W. Va.

MOTHER
14. Maiden name: Stella(Unknown)
15. Birthplace: Onega, W. Va.

16. Informant: John W. Boone

Address: 133. Potomac St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/29/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov. 29 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26th., 1945 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions (large colloid goitre)	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Laurence H. Boone M.D.
Cumberland, Maryland. M. D. or other
Address Date signed 11-26-45
Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

10604

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 21 N. Prospect Square

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 N. Prospect Square

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wm. Kirk Boor

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Louisa E. Athey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1867

8. AGE: Years 78 | Months 2 | Days 0 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co., Md (Town, county, and state)

10. Usual occupation Retired Ticket Agent

11. Industry or business W. Md. Railway.

FATHER 12. Name John Boor

13. Birthplace Bedford Valley Pa.

MOTHER 14. Maiden name Delilah ——

15. Birthplace Unknown

16. Informant Mrs. Ada Warnick

Address 21 N. Prospect Square Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15, 1945 (month) (day) (year)

Cemetery or crematory Queens Point Cemetery

Location Keyser W. Va.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Nov 15 1945 (Date rec'd by registrar) Walter R. Beall Registrar

MEDICAL CERTIFICATION about P.

20. DATE OF DEATH November 12th., 1945 at 6.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ———

Date of op.

Autopsy results noautopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Prince H. Bouse, M. D. M. D. or other

Address Cumberland, Maryland Date signed 11-13-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

10605

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 1 hr. and 38 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt. Savage, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy Bridges

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	New Born

B.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 5, 1945

8. AGE: Years	Months	Days	If less than one day
			1 hrs. 38 min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Robert Bridges

13. Birthplace Elk Garden, W. Va

MOTHER 14. Maiden name Wauneta Lease

15. Birthplace Mt. Cresaptown, Md

16. Informant Robert Bridges

Address Mt. Savage, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Nov 8, 1945 (month) (day) (year)

Cemetery or crematory Hafer's Funeral Service

Location Cumberland, Md

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Nov 8 1945 (Date rec'd by registrar) Winters R. Brantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1945, at 11:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 5 1945, to Nov 5 1945 and that I last saw h[illegible] alive on Nov 5 1945

Immediate cause of death	DURATION
Premature	
Six months.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E Lester M. D. or other

Address 122 Bedford St Date signed 11/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10606

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs 9

Hospital, Institution, or street address where death occurred: 14 So. Chase St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 14 S. Chase St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Katherine Burkey

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Jerome J Burkey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 3 1871

8. AGE:

Years	Months	Days	If less than one day
74	7	25	..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Urban Miller

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth Rang

15. Birthplace Germany

16. Informant Jerome Burkey

Address 14 S Chase St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 1 1945 (month) (day) (year)

Cemetery or crematory St Peter & Paul

Location Fayette St Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland Md

19. Dec. 1, 1945 Jos P Frawley M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945 at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-1-45 to 11-28-45

and that I last saw h alive on 11-28-45

Immediate cause of death	DURATION
Myocarditis, Chronic	3 mo.
Due to Cancer	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J C Edwards M.D.

M. D. or other

Address Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

10607

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years.

Hospital, institution, or street address where death occurred: 171 Oak St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 171 Oak St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Chamberlain

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Anna Eisenhuth

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 5 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	10	1		

9. Birthplace: Weatherly, Pa.
(Town, county, and State)

10. Usual occupation: Lumber dealer.

11. Industry or business: Retired

FATHER
12. Name: Wm Chamberlain
13. Birthplace: Pa.

MOTHER
14. Maiden name: Unknown.
15. Birthplace: ____

16. Informant: Mrs Chas E Howdyshell
Address: 171 Oak St.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: 11-9-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Nov 8 1945 (Date rec'd by registrar) E. Hunter Tracy M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1945, to Nov. 6, 1945, and that I last saw h— alive on Nov. 5, 1945.

Immediate cause of death	DURATION
(a) Generalized Tuberculosis	5 yrs.
Due to: (b) Pneumonia	4 wks
Due to: (c)	
Due to: (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Clay E. Tracy M.D.

Address: Cumberland, Md. Date signed: Nov. 7, 1945

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10608

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Chestnut St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Westernport-Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1/4 Mi W. Of Westernport
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Arnold Gerstell Clark

3.(b) Social Security Number: 212-12-8117

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower.

6.(b) Name of husband or wife: Elizabeth Clark
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 22, 1865

8. AGE: Years	Months	Days	If less than one day
80	4	12	..... hrs. ..... min.

9. Birthplace: Dawson-Allegany- Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Plup & Paper Mill

FATHER
12. Name: Wesley Clark
13. Birthplace: Dawson, Md.

MOTHER
14. Maiden name: Lacey Ann Dawson
15. Birthplace: Dawson, Md.

16. Informant: Arthur Clark
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 7 45 (month) (day) (year)
Cemetery or crematory: Philos Cem.
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal.
Address: Westernport, Md.

Nov 5 19 45 (Date rec'd by registrar) A. Grayson Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4, 19 45 at 5.45P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 25 19 45 to Nov 4 19 45 and that I last saw h[illegible] alive on Nov 4 19 45

Immediate cause of death	DURATION
Coronia-Thrombosis	
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Reaves M.D. M. D. or other
Address: Westernport Md. Date signed 11/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

(M)

MARGIN RESERVED FOR BINDING

(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

10609

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, Institution, or street address where death occurred:
15. Prospect Square

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15. Prospect Square
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Roderic Clary

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Victoria Clary

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9 1854

8. AGE: Years	Months	Days	If less than one day
91	6	28	hrs. min.

9. Birthplace: Frostburg, Allegany Co, Maryland
(Town, county and state)

10. Usual occupation: Chief Clerk and Paymaster (Retired)

11. Industry or business: Penna. R. R. Co.

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Roderic Clary, Jr.

Address: Reading, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/9/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov. 9 19 45 (Date rec'd by registrar) Winter K. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 19 45 at 5-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 45 to October 26 19 45 and that I last saw h[illegible] alive on October 26 19 45

Immediate cause of death	DURATION
Arteriosclerosis	Unknown
Due to	
Due to	
Other conditions: Senility	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. D. Johnson M.D.
M. D. or other

Address: Cumberland, Md. Date signed: 11-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10618

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, Institution, or street address where death occurred:
113 Park Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewboro iofaots give resideoce of mother)

State Md. County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Park Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Cole Jr.

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Nettie Gales.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept-15-1872

8. AGE: Years 73 | Months 1 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace Middlethia Allegany Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Coal Miner

FATHER 12. Name Wm. Cole

13. Birthplace Unknown

MOTHER 14. Maiden name Louise Thomas

15. Birthplace Unknown

16. Informant Harry M. Cole

Address Box 93 Piedmont W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4-1945 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director Jacob Wade

Address Frostburg, Md.

19. 11-3 (Date rec'd by registrar) 19 45 Mrs. Nancy A. Doe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 19 45 at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19 .. to Nov 1 19 45 and that I last saw h.. alive on Oct 26 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	Several years
Due to	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Cane Jr. M.D.
M. D. or other

Address Frostburg Md. Date signed Nov 3 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martin Patrick Cawley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Margaret Chapman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 11 - 1863

8. AGE: Years	Months	Days	If less than one day
82	7	21	..... hrs. ..... min.

9. Birthplace Piedmont, W. Va.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Coal Operator

FATHER 12. Name Peter Cawley

13. Birthplace Ireland

MOTHER 14. Maiden name Margaret Cawley

15. Birthplace Ireland

16. Informant Mrs Irene Cawley

Address 1 Broadway Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 9 1945 (month) (day) (year)

Cemetery or crematory St Michaels Cem

Location Frostburg, Md

18. Funeral director Jacob Yaden

Address Frostburg, Md

19. 11-8 1945 Mrs Nancy A. Roe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1945, at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19.. to Nov 6 1945

and that I last saw ~~him~~ alive on Nov 6 1945

Immediate cause of death	DURATION
Abscess Myocarditis	several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W M Lane M D

M. D. or other

Address Frostburg Md Date signed 11-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10612

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, Institution, or street address where death occurred: East Main Street

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: East Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: George Corstorphine

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret Blackburn

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug. 23, 1858

8. AGE:

Years	Months	Days	If less than one day
87	2	14	... hrs. ... min.

9. Birthplace: Glascow, Scotland (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Georges Creek Coal Mining Co.

FATHER
12. Name: Corstorphine
13. Birthplace: Scotland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Scotland

16. Informant: George Gardner
Address: Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 9 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing Md

18. Funeral director: M. Sieafhorn

Address: Lonaconing Md

19. Nov. 9 1945 (Date rec'd by registrar) D. E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1945 to Nov. 7 1945 and that I last saw him alive on Nov. 6 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury — Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing Md Date signed: Nov. 9 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10613

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Klondike

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: Route 1 Frostburg

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Klondike

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 1 Frostburg

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Wm. Henry Cunningham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rosa McKenzie

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) March 12, 1883

8. AGE: Years	Months	Days	If less than one day
62	8	5	..... hrs. ..... min.

9. Birthplace Newburg W. Va. (town, county, and state)

10. Usual occupation Supt of Traffic

11. Industry or business Celanese Corp.

FATHER 12. Name Wm Cunningham

13. Birthplace Scotland

MOTHER 14. Maiden name Emma Wolfe

15. Birthplace Kingwood W. Va

16. Informant Mrs. Milnor Bruce

Address 103 Washington St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20, 1945 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Nov. 19 1945 (Date rec'd by registrar) Dr. E. Owen Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1945 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	Sudden death
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Henry M. Hodgson M.D. M. D. or other

Address Lonaconing Md. Date signed Nov. 19, 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

10634

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Williams Rd. R.F.D. #2

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: John Albert Davis

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 9 1945

8. AGE: Years	Months	Days	If less than one day
	1	2	____ hrs. ____ min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Harvey N. Davis

13. Birthplace: Md.

MOTHER — 14. Maiden name: Ella Glos

15. Birthplace: Md.

16. Informant: Harvey N. Davis

Address: R.F.D. # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-13-45 (month) (day) (year)

Cemetery or crematory: Ent Herman Cem.

Location: R.F.D. # 2 Cumberland

18. Funeral director: Gonia Sisters Inc.

Address: Cumberland

19. Nov. 13 1945 (Date rec'd by registrar) Walter R. Beauchamp M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11th, 1945 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____ and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Malnutrition	
Congenital inanition	since birth
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ____

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Bruce H. Bolton M.D. M. D. or other

Address: Cumberland, Allegany, Md. Date signed 11-12-4

WITHIN CORPORATE LIMITS

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

10615

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 MONTH

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town FRIENDSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
MR. LAFAYETTE DeWITT

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife TRESSA SAVAGE
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APRIL 8, 1862

8. AGE: Years	Months	Days	If less than one day
83	7	7	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual occupation UNABLE TO WORK
11. Industry or business
FATHER 12. Name THOMAS DeWITT
13. Birthplace Maryland
MOTHER 14. Maiden name NANCY DeWITT
15. Birthplace Maryland
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18, 1945 (month) (day) (year)
Cemetery or crematory Sang Run Cem
Location Sang Run, Md.
18. Funeral director W. W. Savage
Address Friendsville, Md.
19. Nov. 17 1945 (Data rec'd by registrar) Joseph P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 15 1945 at 10:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Nov 15 1945 and that I last saw him alive on Nov 15 1945

	DURATION
Immediate cause of death Gangrene of right foot	
Due to Senility - Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. A. Gracie M. D. or other
Address Cumberland Md Date signed

(M)

(I)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Dr. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

10616

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Rose Digiustino

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Joseph Digiustino

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) May 29, 1892

8. AGE: Years	Months	Days	If less than one day
53	5	26	hrs. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Torulle

13. Birthplace Italy

MOTHER 14. Maiden name Gladina Dascanto

15. Birthplace Italy

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/29/45 (month) (day) (year)

Cemetery or crematory Kalbaugh Cemetery

Location Elk Garden, W. Va.

18. Funeral director O. F. Sharpless

Address Blaine, W. Va.

19. Nov 29 1945 Jos. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1945, at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1945 to Nov 25 1945 and that I last saw h alive on Nov 25 1945

Immediate cause of death	DURATION
Treated for, Hemorrhagic pancreatitis	about 2 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Hemorrhagic pancreatitis Date of op. 11-20-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M.D. M. D. or other

Address Cumberland Md. Date signed 11-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

Dr. Hodges

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10617

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 131 Offutt Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Boy Divelbliss

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 23, 1945

8. AGE: Years | Months | Days | If less than one day: 2 hrs. ..... min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: New born

11. Industry or business:

FATHER — 12. Name:

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Mabel Divelbliss

MOTHER — 15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Nov. 23 1945 (month) (day) (year)

Cemetery or crematory: Memorial Hosp.

Location: Cumberland, Md.

18. Funeral director: Sauer

Address:

19. Nov 23, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23, 1945 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23 1945 to Nov. 23 1945 and that I last saw him alive on Nov. 23 1945.

Immediate cause of death	DURATION
Prematurity	6 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ..... Injured at work?

23. SIGNATURE: W Rope Hodges M. D. or other

Address: Cumberland, Md. Date signed 11/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

10618

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: Main Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Catherine McHugh Doolan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Patrick Doolan
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): Jan. 16, 1881

8. AGE:

Years	Months	Days	If less than one day
64	10	3	... hrs. ... min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home

FATHER
12. Name: Thomas McHugh
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Conway
15. Birthplace: Ireland

16. Informant: Patrick Doolan
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 24 1945 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Lonaconing, Md.
18. Funeral director: D. E. Eichhorn
Address: Lonaconing, Md.
19. Nov. 21st 1945 (Date rec'd by registrar) D. E. Oughton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19th 1945, at 3 45 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19th 1945, to ... 19..., and that I last saw h... alive on Nov. 19- 1945

Immediate cause of death	DURATION
Coronary Occlusion (Sudden)	
Due to: Angina Pectoris	4 hours
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

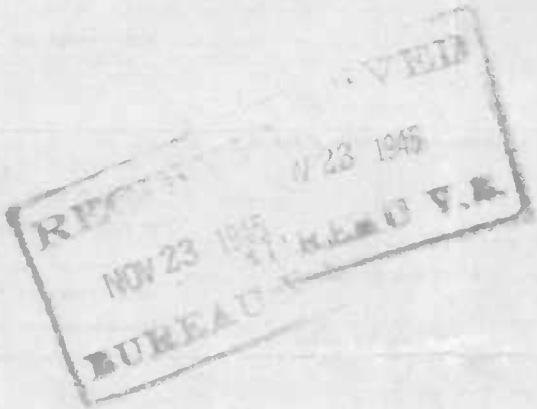
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Dr. E. Doughton M. D. or other
Address: Lonaconing Date signed 11/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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NOV 23 1945
BUREAU

10619

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ellen Cecelia Drum

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26, 1914

8. AGE:

Years	Months	Days	If less than one day
31	3	23	hrs. min.

9. Birthplace: Eckhart Allegany Cty, Md
(Town, county, and state)

10. Usual occupation: invalid

11. Industry or business

FATHER
12. Name: Patrick Drum
13. Birthplace: Maryland

MOTHER
14. Maiden name: Katherine Durkin
15. Birthplace: Pennsylvania

16. Informant: Mrs. Anthony Bollino
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Nov. 26, 1945 (month) (day) (year)
Cemetery or crematory: St. Michael's
Location: Frostburg Md.

18. Funeral director: J. J. Durbin
Address: Frostburg, Md.

19. 11-24 1945 Mc. Bailey R-Reg
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1945 at 1100 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Nov 23 1945
and that I last saw her alive on Nov 9 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Several years
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: W. M. Lane Jr MD M. D. or other
Address: Frostburg Md Date signed: Nov 24 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-E

CERTIFICATE OF DEATH

10620 5

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Sara Jane Elliott

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Nov. 3, 1873

8. AGE:

Years	Months	Days	If less than one day
72	0	14	...hrs. ...min.

9. Birthplace: Lonaconing Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: John B. Elliott
13. Birthplace: England
MOTHER 14. Maiden name: Sarilla Shockey
15. Birthplace: Wellsburg, Pa.
16. Informant: Mrs. Richard Elliott
Address: Midland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: W. M. Eichhorn
Address: Lonaconing, Md.
19. Nov. 19 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17, 1945, at 12:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 1945, to November 17 1945
and that I last saw h... alive on October 29 1945

Immediate cause of death	DURATION
cause of the	6 months
Signed	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) —
Means of Injury — Injured at work?

23. SIGNATURE: L. Wingo M.D.
M. D. or other
Address: Long Hill Date signed: 11-18-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10621

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 431 Pennsylvania Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 431 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Margaret Ellen Emerick

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jefferson A. Emerick

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 8, 1868

8. AGE: Years	Months	Days	If less than one day
77	0	7	hrs. min.

9. Birthplace: Eckhart Mines, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home

FATHER
12. Name: Samuel Myers
13. Birthplace: Preston County W. Va.

MOTHER
14. Maiden name: Nancy Harden
15. Birthplace: Eckhart Md.

16. Informant: Elmer C. Emerick

Address: 710 South St -- Cumberland Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov 17, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Nov. 17, 19 45 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 1945, at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15, 1945 to Nov. 15, 1945 and that I last saw h[illegible] alive on Nov. 14 1945

Immediate cause of death	DURATION
Uremia	6 wks
Due to Nephrosclerosis	5 yrs.
Due to Generalized Arteriosclerosis	15 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clay F. Turner M. D. or other

Address: Cumberland Md. Date signed: Nov. 16, 1945

Burial

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10622

Reg. Diat. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 8 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216 W. Main St.
(If rural give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Entler

3. (b) Social Security Number 220-10-2144

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 4 - 1880

8. AGE: Years 65 | Months 8 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Clarysville, Allegany, Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Coal Mine

FATHER 12. Name George Entler

13. Birthplace Germany

MOTHER 14. Maiden name Lena Smith

15. Birthplace Germany

16. Informant Mrs. Ruth Lantz

Address 216 W. Main St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-9-1945 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Jacob L. Bafer

Address Frostburg, Md.

19. 11-8 1945 Mrs. Nancy M. Rae Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1945 at 6:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1945, to Nov 6 1945 and that I last saw h.... alive on Nov 6 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Several Years
Due to	
Due to	
Other conditions Thrombo-Phlebitis Left Leg (Include pregnancy within 3 months of death)	3 months

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. O. M. Lane Jr. M.D.
M. D. or other

Address Frostburg, Md. Date signed 11-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10623

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo 15 days.
Hospital, Institution, or street address where death occurred:
Memorial Hospital.
How long in hospital or institution? 3 1/2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 58 Cresap St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ann Eberly Sloan

3. (b) Social Security Number None

4. Sex Female | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13 1945

8. AGE: Years | Months 4 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name James H. Eberly
13. Birthplace Md.

MOTHER 14. Maiden name Wilda Albright
15. Birthplace Pa.

16. Informant Mrs James H Eberly
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Doc

Address Cumberland

19. Nov 2 1945 Winter R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1945 at 6 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1945 to Nov 1 1945 and that I last saw h... alive on Oct 31 1945

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J Bailey Hunter M.D. M. D. or other

Address Cumberland Md Date signed 11/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-D

CERTIFICATE OF DEATH

10624

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 21 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 729 PATTERSON AVE.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
ADA M. FISHER

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife CHARLES M. FISHER

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) AUG. 6, 1880

8. AGE: Years	Months	Days	If less than one day
65	3	15	hrs. min.

9. Birthplace [illegible]. Confluence, Somerset, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name JAMES WOODMANCY
13. Birthplace Pa.

MOTHER
14. Maiden name Isabelle McAneer
15. Birthplace Pa.

16. Informant Charles M. Fisher
Address 729 Patterson Ave.

17. Burial Date thereof Nov 23, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest

Location Cumberland Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Nov 27 1945 Jos. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1945, at 6.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-23- 1944, to 11-21- 1945 and that I last saw h[illegible] alive on 11-20- 1945

Immediate cause of death	DURATION
Carcinomatosis of abdominal viscera	
Due to	
Due to Carcinoma of Sigmoid.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 11-21-45

WITHIN CORPORATE LIMITS

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

Do not mail to city 10625

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town FLINTSTONE
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MR. JESSE FLETCHER

3.(b) Social Security Number
220-10-7471

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife IDA IMES

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 15, 1874

8. AGE: Years	Months	Days	If less than one day
71	7	18	..... hrs. ..... min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER
12. Name Wm. Fletcher
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5, 1945 (month) (day) (year)

Cemetery or crematory Mt Hope Cemetery

Location East Side of Polish Mountain

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Nov 3, 1945 (Date rec'd by registrar) Walter L. Mantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 3, 1945 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 26, 1945, to NOV. 3, 1945 and that I last saw h... alive on NOV. 1945

Immediate cause of death	DURATION
(a) Chronic Nephritis	10 yrs
Due to (b) Chronic Hypertension	5 yrs
Due to (c) Arteriosclerosis	1 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. L. Elason M.D. M. D. or other

Address 26 Seventh St Cumberland Md Date signed 11/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

10626

CERTIFICATE OF DEATH

★ Reg. Dist. No. 14

1. PLACE OF DEATH:

County: Allegany

City or town: Hyndman Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Hyndman Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Benjamin Franklin Getz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Rosa Belle Kennell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 2, 1872

8. AGE:

Years	Months	Days	If less than one day
73	8	6	...hrs. ...min.

9. Birthplace: Wellersburg, Pa.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Anthony Getz

13. Birthplace: Pa.

MOTHER 14. Maiden name: Catherine Liston

15. Birthplace: Pa.

16. Informant: Mrs. Irvin Troutman

Address: Hyndman, Pa. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 10 1945 (month) (day) (year)

Cemetery ~~or crematory~~: Hillcrest

Location: Cumberland, Md.

18. Funeral director: Harvey H. Zeigler

Address: Hyndman, Pa.

19. Nov 10 1945 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 19 45, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 45 to November 19 45 and that I last saw him alive on Nov. 8 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John A. Topper M.D. M. D. or other

Address: Hyndman Pa Date signed 11/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8

10627

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:
County: Allegany
City or town: Mt Savage Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Samuel Grady, Jr.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 7-12-37

8. AGE: Years: 8 | Months: 4 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Frostburg Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Charles L. Grady
13. Birthplace: Mt Savage Md

MOTHER
14. Maiden name: Sarah J. Beeman
15. Birthplace: Frostburg Md

16. Informant: Chas L. Grady
Address: Mt Savage Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 11-29-45
Cemetery or crematory: St Patricks
Location: Mt Savage, Md

18. Funeral director: Harvey L. Bridger
Address: Hyndman, Pa

19. 11-29-45 (Date rec'd by registrar) Verna McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28th., 19 45 at about 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Spinal Meningitis	15 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Percival H. Dorsey, M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 11-28-45
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10628

Reg. Diat. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs

Hospital, institution, or street address where death occurred: 317 Md. Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 317 Md. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Benjiman Harry Vernon Green

3.(b) Social Security Number: 217-05-1526

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Heatly Green

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Aug 8, 1885

8. AGE:	Years	Months	Days	If less than one day
	60	3	5	...hrs. ...min.

9. Birthplace: Barton-Allegany-Md. (Town, county, and state)

10. Usual occupation: Filter-House Operator

11. Industry or business: Paper-Mill

FATHER 12. Name: Benjiman Green

FATHER 13. Birthplace: Not known

MOTHER 14. Maiden name: Susan Dawson

MOTHER 15. Birthplace: Not Known

16. Informant: Mrs. Margaret Green

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 45. (month) (day) (year)

Cemetery or crematory: Philos Cem.

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Nov. 14 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13, 1945, at 8. a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1945 19... to Nov 13 1945

and that I last saw him alive on Nog 12th 1945 19...

Immediate cause of death	DURATION
Carcinoma of the stomach,	1yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Piedmont W Va. Date signed 11/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10629

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred: 20 Main.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 20 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Habeeb

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Victoria Habeeb
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 1, 1871

8. AGE: Years	Months	Days	If less than one day
74	4	2	..... hrs. ..... min.

9. Birthplace: Mt. Lebanon-Asyria (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Confectionary

FATHER
12. Name: Elias Habeeb
13. Birthplace: Asyria

MOTHER
14. Maiden name: Not Known
15. Birthplace

16. Informant: Joseph Habeeb
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 6, 45. (month) (day) (year)
Cemetery or crematory: St. Peters Cem.
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. Nov. 7 19 45 G. Raymbaker M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov., 3 19 45, at 8.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 19 45 to Nov 3 19 45 and that I last saw h- alive on Nov 3 19 45

Immediate cause of death	DURATION
Cerebral embolism	3 days
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Westernport Md. Date signed 11/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10630

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 yrs 1 mo 11 ds

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 1 mo 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Zihlman (If outside city or town limits, write RURAL and give nearest town)

Street No. R. 2. No 2 Frostburg (If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME William Hamilton

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Baxter 6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Sept. 17-1886

8. AGE: Years 59 Months 1 Days 11 If less than one day ..... hrs. ..... min.

8. Birthplace Zihlman, Allegany, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Truck Stop

FATHER 12. Name Wm. Hamilton

13. Birthplace Baltimore, Md

MOTHER 14. Maiden name Sarah Stevens

15. Birthplace Zihlman, Md

16. Informant Mr. Howard Orr

Address R. 2. No 2 Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30-1945 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Joseph Baker

Address Frostburg, Md.

19. 11-29 1945 Mrs. Nancy M. Roe Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 23 1945, to Nov 28 1945 and that I last saw h— alive on Nov 27 1945

	DURATION
Immediate cause of death	
Broncho Pneumonia	2 Days
Due to	
Influenza	4 Days
Due to	
Other conditions Bronchial Asthma	many years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. D. M. Lane M.D. M. D. or other

Address Frostburg Md. Date signed Nov 28 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94h)

CERTIFICATE OF DEATH

10631

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 444 Central Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William A Hanekamp

3.(b) Social Security Number: 705-05-8530

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie M. Humphrey

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): April 1, 1898

8. AGE:

Years	Months	Days	If less than one day
47	7	18	...hrs. ...min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Car Inspector

11. Industry or business: B&O R.R. Co. - Cumberland

FATHER — 12. Name: William Hanekamp

FATHER — 13. Birthplace: Lonaconing Md.

MOTHER — 14. Maiden name: Sara Holder

MOTHER — 15. Birthplace: Lonaconing Md

16. Informant: Chas. D. Hanekamp

Address: Cumberland - Route 3, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 22, 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemeteries

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing Md.

19. Nov. 22 1945 Jos. H. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19 1945, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1945, to November 19 1945 and that I last saw h... alive on November 19 1945

Immediate cause of death	DURATION
acute coronary occlusion	3 days
Due to: arteriosclerosis	4
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: C. Hanekamp M.D. M. D. or other

Address: Lonaconing Md. Date signed 11-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55)

10632

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 Years

Hospital, Institution, or street address where death occurred:

218. Davidson St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 218. Davidson St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Maude Harrison

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 19 1881

8. AGE: Years	Months	Days	If less than one day
64	3	11	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Maryland (Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER

12. Name: William J. Harrison

13. Birthplace: Clearspring, Md.

MOTHER

14. Maiden name: Elizabeth Heavener

15. Birthplace: Cumberland, Md.

16. Informant: Miss Bessie Harrison

Address 218. Davidson St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/2/45 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec. 1 (Date rec'd by registrar) 19 45 Joseph O. Mathews M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 19 45 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 30 19 45 to November 30 19 45 and that I last saw h... alive on November 30 19 45

Immediate cause of death	DURATION
Carcinoma Left Breast	6 months
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Antopsy results

PHYSICIAN: Please nnderline the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Blanche M. Schneider M. D. or other

Address 41 Greene St Date signed Nov. 30, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. TOLSON

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

10638

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VA. County MINERAL

City or town KEYSER

(If outside city or town limits, write RURAL and give nearest town)

Street No. 92 Third Street

(If rural, give LOCATION)

2.(a) Ll veteran, name war

3. (a) FULL NAME HEDRICK, ARLIE MR.

3. (b) Social Security Number 705-05-9705

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

B.(b) Name of husband or wife SHIELENBURG, FANNIE

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 5, 1888

8. AGE: Years	Months	Days	If less than one day
57	—	—	..... hrs. ..... min.

9. Birthplace W. VA. (Town, county, and state)

10. Usual occupation HOSTLER @ B. & O. R.R.

11. Industry or business BALTIMORE & OHIO R.R.

FATHER 12. Name HEDRICK, JOSEPH

13. Birthplace W. VA.

MOTHER 14. Maiden name REXRODE, ELIZA

15. Birthplace W. VA.

16. Informant Memorial Hospital

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1945 (month) (day) (year)

Cemetery or crematory Queens Point Cem

Location Keyser, W. Va.

18. Funeral director Markwood Funeral Home

Address Keyser, W. Va.

19. Nov 6, 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 5, 1945, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-25- 1945, to 11-5- 1945 and that I last saw h.i.m alive on 11-5-45 1945

Immediate cause of death	DURATION
Benign hypertrophy prostate	
Due to	
Due to	
Other conditions Myocardial degeneration	
(Include pregnancy within 3 months of death)	
Major findings of operations enlarged prostate	
Date of op. 11-5-45	

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Howard L. Tolson M. D. or other

Address Cumberland, Md Date signed 11-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

10634

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred: Memorial Hospital

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Weverton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Newton C. Hines

3.(b) Social Security Number 705-09-7696

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Laurette Castle Hines

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.): July 25, 1902

8. AGE: Years 43 | Months 4 | Days 1 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: B. and O. R.R. Co.

FATHER — 12. Name: Samuel Hines; 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anna Pierce; 15. Birthplace: Maryland

16. Informant: Mrs. Laurelle Hines

Address: Weverton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 29, 1945 (month) (day) (year)

Cemetery or crematory: Church of the Brethern

Location: Brownsville, Md.

18. Funeral director: Leroy Fete

Address: Brunswick, Md.

19. Nov. 29, 19 45 (Date rec'd by registrar) Jos. S. Franklin, M.D. Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH November 26th., 19 45, at 2.20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death: Crushed pelvis; amputation of left foot (crushed) at ankle; — DURATION: 4 days, 3 hrs. 45 min.

Due to: ruptured bladder and bowel. —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: as above, foot amt., repair of bladder and bowel. Date of op.

Autopsy results: no autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: accident Date of 11-22-45

Where did injury occur? Cumberland, (City or town) Allegany, (County) Md. (State)

Injured at home, farm, industry, public place (where?) R.R. Yards

Means of injury struck by train Injured at work? yes

23. SIGNATURE: Pierce H. Brown, M.D. (M. D. or other)

Address: Cumberland, Maryland Date signed: 11-27-45

Deputy Medical Examiner - Allegany Co.

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a1

CERTIFICATE OF DEATH

10635

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, Institution, or street address where death occurred: 70 N. Mechanic St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 70 N. Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME A. Michael Hogan

3. (b) Social Security Number 214-05-7692

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 9 1875

8. AGE: Years 70 | Months — | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Westernport Md.
(Town, county, and state)

10. Usual occupation Bar tender

11. Industry or business Restaurant

FATHER 12. Name Michael Hogan
13. Birthplace Md.

MOTHER 14. Maiden name Bridget Foley
15. Birthplace Md.

16. Informant Mrs Eugene Lapton
Address Westernport Md

17. Burial (Burial, cremation, or removal) Date thereof Nov 28 '45 (month) (day) (year)
Cemetery or crematory St Peters Cath. Cem
Location Westernport Md

18. Funeral director Fredlock Funeral Home
Address Piedmont W. Va.

19. Nov 26 19 45 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25th, 19 45 at about 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben H. Boyce M.D.
Address Cumberland, Maryland M. D. or other
Date signed 11-25-45
Deputy Medical Examiner - Allegany Co.

WITHIN CORPORATE LIMITS

10636

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71. Years

Hospital, institution, or street address where death occurred: 702. Gephart Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 702. Gephart Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Albert A. Hughes

3.(b) Social Security Number: 214-07-4289

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Matilda Hughes

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 14, 1874

8. AGE: Years	Months	Days	If less than one day
71	4	1	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Maryland (Town, county, and state)

10. Usual occupation: Machinest Helper

11. Industry or business: Celenese Corporation

FATHER 12. Name: Joseph Hughes

FATHER 13. Birthplace: Cumberland, Md.

MOTHER 14. Maiden name: Minnie Daun

MOTHER 15. Birthplace: Berlin, Germany

16. Informant: Mrs. Matilda Hughes

Address: 702. Gephart Drive, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/18/45 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: William H. Kight

Address: Cumberland Md.

19. Nov. 17, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15th., 1945 at 5.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Pierce H. Bowen M.D. M. D. or other

Address: Cumberland, Maryland. Date signed: 11-15-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS
Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

10637

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany County Infirmary
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 767 Maryland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Iser

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Margaret C. Iser
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 4, 1864

8. AGE: Years	Months	Days	If less than one day
81	1	12	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Bridlesmaker - (Retired)
11. Industry or business: B. and O. R.R.

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name:
15. Birthplace

16. Informant: Allegany County Infirmary
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 18, 1945 (month) (day) (year)
Cemetery or crematory: Allegany County Home Cem.
Location: Cumberland

18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19. Nov. 17 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16, 1945 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 7 1941, to Nov 16 1945
and that I last saw him alive on Nov. 13 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis.	
Due to Senilmitrias Ft.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 11.16.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

DR. ELIASON

10638

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 18 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 31 OFFUTT ST. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME DEL RAY MORRIS JONES

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 31, 1945

8. AGE: Years	Months	Days	If less than one day
	2 ~~Months~~	2	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Maurice Jones

13. Birthplace Streby, W. Va.

MOTHER 14. Maiden name MARIE RIGGLEMAN

15. Birthplace Jordan Run, W. Va.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5, 1945 (month) (day) (year)

Cemetery or crematory Jordan Run Cemetery

Location Jordan Run, W. Va.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Nov 4 1945 (Date rec'd by registrar) Winter R. Tranter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 3, 1945, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 16 1945, to NOV. 3, 1945 and that I last saw him alive on NOV. 3, 1945

	DURATION
Immediate cause of death Malnutrition	6 wks
Due to Gleocaeta	3 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Eliason M.D. or other

Address 63 Bleury St. Cumberland Md. Date signed 11/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

10639

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Va. County: Mineral.
City or town: Wiley Ford.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World WAR #2. ✓

3. (a) FULL NAME: Harry Russell Keller

3. (b) Social Security Number: 217-10-5233

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Catherine Virginia Riley
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): aug 18 1913

8. AGE: Years	Months	Days	If less than one day
32.	2	23	hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)
10. Usual occupation: Machinist Helper
11. Industry or business: B & O. R.R.
FATHER 12. Name: Russell Wis Keller
13. Birthplace: Md.
MOTHER 14. Maiden name: Martha Storey
15. Birthplace: Md.
16. Informant: Catherine Keller
Address: Wiley Ford W. Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/45 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland Md.
18. Funeral director: Lewis Steele Inc.
Address: Cumberland Md.
19. Nov. 17, 1945 Winter L. Frank M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH: November 11th., 19 45, at 6.20 M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Fractured skull, with extra-	16 hrs.
dural hemorrhage, causing	
Due to: compression of brain.	
Findings: rupture of external middle meningeal	
Due to: artery. C.W.O.P.	
Accidental fall. C.W.O.P.	
Other conditions: No evidence of foul play.	

(Include pregnancy within 3 months of death)

Major findings at operation: no operation
Date of op.: base.
Autopsy results: fractl left parietal, ext. into
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: under investigation Date of: 11-11-45
Where did injury occur? Cumberland, Allegany Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): hotel
Means of injury: undetermined Injured at work? no

23. SIGNATURE: Prince H. Bosley M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 11-12-45
Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 20 1945
BUREAU

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

10640

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred: 110 Bedford St Fronty Apt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Rebecca Kimes

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Wm Kimes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 21 1854

8. AGE: Years	Months	Days	If less than one day
91	4	20	..... hrs. ..... min.

9. Birthplace Romney W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home.

FATHER 12. Name Reuben Snyder.

13. Birthplace Va.

MOTHER 14. Maiden name Margaret Easter

15. Birthplace Va.

16. Informant Leroy Kimes
Address Cumberland.

17. Burial Date thereof Nov 13 '45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Nov. 13, 19 45 Winter R. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 19 45 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 19 44 to Nov 11 19 45 and that I last saw her alive on Nov 11 19 45

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs
Due to Chronic Bronchitis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Winter R. Trautz M.D.
M. D. or other

Address Date signed Nov 13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

10641

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all her life

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 130 E. Main

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Katherine C. Koch

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 19, 1876

8. AGE:

Years	Months	Days	If less than one day
69	8	24	..... hrs. ..... min.

9. Birthplace: Frostburg Allegany Cty Md.
(town, county, and state)

10. Usual occupation: Home

11. Industry or business:

FATHER
12. Name: William H. Koch
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Diana Thomas
15. Birthplace: Pennsylvania

16. Informant: Mrs William Koch,
Address: Wheeling W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 11-15-45 (Date rec'd by registrar) Mrs. Stanley M. Doe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 13 1945 at 6.20 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Aug 11 1945, to Nov 13 1945 and that I last saw her alive on Nov 12 1945

	DURATION
Immediate cause of death: Diabetes	Several years
Due to: Probably Pulmonary Embolism from	Sudden
Due to: diabetes gangrene	
Other conditions of fatal	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. M. Lane Jr. M.D.
M. D. or other

Address: Frostburg Md. Date signed 11-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

10642

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 Shawnee Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American War

3.(a) FULL NAME Jesse Wright Korns

3.(b) Social Security Number 705-05-5175

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen H Spurl

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 29 1883

8. AGE: Years 62 | Months 3 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Crossman

11. Industry or business B & O Ry Shops.

FATHER 12. Name George Korns

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Crothers

15. Birthplace Md.

16. Informant Mrs Jesse W. Korns

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 27 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Nov. 26 1945 Jos. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24th., 1945, at 3.20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary Thrombosis	30 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Prince H. Bowen M.D.
M. D. or other

Address Cumberland, Maryland. Date signed 11-24-45

Deputy Medical Examiner, Allegany

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

10643

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred: Harrison St. B & O Ry Crossing
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Park St.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: Wilbur Selden Landis

3.(b) Social Security Number: 220-10-0842

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine Moore
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 16 1876

8. AGE: Years	Months	Days	If less than one day
69	10	7	____ hrs. ____ min.

9. Birthplace: Port Royal Pa (Town, county, and state)
10. Usual occupation: City Engineering Dept's
11. Industry or business:
FATHER 12. Name: William H Landis
13. Birthplace: Pa.
MOTHER 14. Maiden name: Mary Richardson
15. Birthplace: Pa.
16. Informant: Katherine M. Landis
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26 45 (month) (day) (year)
Cemetery or crematory: Hillcrest Mem.
Location: Cumberland
18. Funeral director: Louis Stein Inc.
Address: Cumberland.
19. Nov. 26 19 45 (Date rec'd by registrar) Joseph P. Franklin Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: November 23rd., 1945 at 6.25 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____ to ____ 19____ and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Decapitation; crushed chest; mult. fractures.	killed instantly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 11-23-45
Where did injury occur? Cumberland, (City or town) Allegany, (County) Md. (State)
Injured at home, farm, Industry, public place (where?): R.R. Crossing
Means of injury: struck by train Injured at work? no

23. SIGNATURE: Pierce H. Brown M.D.
Address: Cumberland, Maryland M. D. or other
Date signed: 11-24-45
Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10644

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred: 202 S. Mechanic St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 S. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Jessie Lee Lewis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(n) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Francis E.B. Lewis

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): May 3, 1878

8. AGE:

Years	Months	Days	If less than one day
67	6	20	x hrs. x min.

9. Birthplace: Middletown Frederick Co, Va (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER

12. Name: Gordon A. Lewis

13. Birthplace: Harpers Ferry W. Va

MOTHER

14. Maiden name: Sallie K. Rhodes

15. Birthplace: Middletown Va.

16. Informant: David R. Lewis

Address: Knoxville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Nov. 25, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15. 1945 to Nov. 23 1945

and that I last saw h alive on Nov. 22 1945

	DURATION
Immediate cause of death: Myocarditis	4 yrs
Due to: Asthma	5 yrs
Due to: Anemia	2 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas. G. Lewis M. D. or other

Address: Cumberland Date signed 11-25-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10645

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro iofaots give residence of mother)

State: W. Va. County: Mineral

City or town: Ridgely
(If outside city or town limits, write RURAL aod give nearest town)

Street No.: Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Francenia Charlotte Lofton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Charles A. Lofton

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 21, 1857

8. AGE:	Years	Months	Days	If less than one day
	88	6	23	____ hrs. ____ min.

9. Birthplace: Hardy Co. W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Aaron Bean
13. Birthplace: W. Va.

MOTHER
14. Maiden name: ____ Buckley
15. Birthplace: W. Va.

16. Informant: James D. Lofton

Address: Rt. 1, Ridgely, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17, 1945 (mooth) (day) (year)

Cemetery or crematory: Asbury Chapel Cemetery

Location: 12 miles south of Moorefield, W. Va.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Nov. 17, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14, 1945, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 11, 1945, to Nov 14, 1945, and that I last saw h... alive on Nov 14, 1945

	DURATION
Immediate cause of death: Fracture R Hip	4 days
Due to: Fall in bedroom	
Due to:	
Other conditions: Senility, Cerebral Embolism (Include pregnaocy within 3 months of death)	

Major fiodiogs of operations: ____ Date of op. ____

Aotopsy results:

PHYSICIAN: Please ooderlioe the caose to which death shoold he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of Nov 11 '45

Where did injury occur? Ridgely (City or town) (County) W. Va. (State)

Injured at home, farm, industry, public place (where?): at Home

Means of injury: Fell in bedroom Injured at work?

23. SIGNATURE: Allen G. Hummel M.D. (M. D. or other)

Address: Cumberland, Md. Date signed: Nov 14 '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10646

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Yr.

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Donna Jean Metz

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1944

8. AGE: Years	Months	Days	If less than one day
0	11	28	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Robert E. Metz

13. Birthplace: Grantsville, Md.

MOTHER — 14. Maiden name: Leola Shepherd

15. Birthplace: Cresaptown, Md.

16. Informant: Robert E. Metz

Address: Cresaptown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 1, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland, Maryland

18. Funeral director: Charles L. George

Address: Cumberland, Maryland

19. Nov. 30 1945 (Date rec'd by registrar) Jos. A. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 28, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27 1945, to Nov. 28 1945 and that I last saw h.. alive on November 28 1945

Immediate cause of death	DURATION
(a) gastro-enteritis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M.D. (M. D. or other)

Address: Long Meadow Date signed 11-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Diehl 10647

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Vencenza Montana

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Martin Montana

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 30, 1892

8. AGE: Years	Months	Days	If less than one day
53	2	20	..... hrs. ..... min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: unknown

13. Birthplace

MOTHER 14. Maiden name: Rosa Nora

15. Birthplace: Italy

18. Informant: Joseph Montana

Address: Eckhart Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Nov. 23 1945 (month) (day) (year)

Cemetery or crematory: St. Michaels

Location: Frostburg, Md

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. 11-22 1945 Mrs. Mary N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 1945 to November 21 1945

and that I last saw her alive on November 21 1945.

Immediate cause of death	DURATION
Acute Cardiac Dilitation	1 day
Due to: Hypertension	
arteris-sclerosis	
Due to: Cystis thyroid	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X

Date of op.

Autopsy results: X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.

M. D. or other

Address: Frostburg, Md. Date signed 11/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

10648

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Monongalia
City or town: Morgantown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pietro Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rebecca Dunn Moore

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John L. Moore
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): November 5, 1885

8. AGE: Years: 60 Months: 0 Days: 20 If less than one day: hrs. min.

9. Birthplace: Edinburgh Scotland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: Nathaniel Dunn
13. Birthplace: Barton Md.

MOTHER
14. Maiden name: Janet Nilson
15. Birthplace: Scotland

16. Informant: Mrs. Clifton Seifarth
Address: Hoffman Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Nov. 28-1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.

18. Funeral director: J. J. Durst
Address: Frostburg Md.

19. 11-27 1945 Mrs. Nadey H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 25 1945, at 1:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1945 to Nov 25 1945
and that I last saw her alive on Nov 25 1940

Immediate cause of death	DURATION
Coronary Thrombosis	18 hrs
Due to	
Due to	
Other conditions: Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. McLane Jr. M.D.
M. D. or other
Address: Frostburg Md. Date signed: 11-29-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

10649

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 2 Years 4 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 206. Decatur St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Martha Morris

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John E. Morris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 22 1863

8. AGE: Years	Months	Days	If less than one day
82	4	13	..... hrs. ..... min.

9. Birthplace: Hyndman, Bedford Co., Penna.
(Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: " "

FATHER
12. Name: Greenberry DeVore
13. Birthplace: Hyndman, Pa

MOTHER
14. Maiden name: Drusilla Carpenter
15. Birthplace: Hyndman, Pa.

16. Informant: Mrs. A. R. White

Address: 217. Dexter Place, Cumbd, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/1/45 (month) (day) (year)

Cemetery or crematory: Trinity Luthern Cem

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland.

19. Dec 1 (Date rec'd by registrar) 19 45 Joseph P. Zuke M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1945 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1945 to Nov. 29 1945 and that I last saw him alive on Nov. 28 1945

DURATION

Immediate cause of death: Generalized Arteriosclerosis ?

Due to: Cystitis 5 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 11-30-45

WITHIN CORPORATE LIMITS

10650

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred: Cor. of Valley and Centre Streets

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Moscow (If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Frank Benjamin Myers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lucy Gaslity Myers

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Oct 17, 1871

8. AGE: Years	Months	Days	If less than one day
74	0	16	hrs. min.

9. Birthplace: Moscow Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business: Maryland Coal Co.

FATHER — 12. Name: Benjamin F. Myers

FATHER — 13. Birthplace: Moscow, Md

MOTHER — 14. Maiden name: Catherine Green

MOTHER — 15. Birthplace: Moscow, Md.

16. Informant: Mrs. James Groves

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow, Md.

18. Funeral director: W. Eichhorn

Address: Lonaconing, Md

19. Nov 5 1945 (Date rec'd by registrar) Wm. R. Frank, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3, 1945 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1945 to Nov 3 1945 and that I last saw him alive on Nov 3 1945

Immediate cause of death	DURATION
Renal Carcinoma	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: D Kester M. D. or other

Address: 122 Bedford St Date signed 11/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

10651

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

S. Lee St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Allegheny

City or town Pittsburgh Pa.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1840 Morningside ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr Alexander Clellan Naismith

3.(b) Social Security Number 208-01-3633

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Louise Soost

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1892

8. AGE: Years 53 | Months 3 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Pittsburgh, Allegheny Co., Md.
(Town, county, and state)

10. Usual occupation Manager

11. Industry or business National Biscuit Co Branch

FATHER 12. Name Samuel Naismith

13. Birthplace Scotland

MOTHER 14. Maiden name Elizabeth Clellan

15. Birthplace Scotland

16. Informant Mrs Ina Berry

Address 1840 Morningside Ave Pittsburgh Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15 1945 (month) (day) (year)

Cemetery or crematory Allegheny Cemetery

Location Pittsburgh Pa

18. Funeral director John D. Hafer

Address Cumberland, Md.

Nov 13 1945 Hunter R. Dent, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1945 at 10.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Prince H. Bosley M.D. M. D. or other

Address Cumberland, Maryland. Date signed 11-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

10652

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany.
City or town: Westernport.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany.
City or town: Westernport.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 119 Church
(If rural, give LOCATION)
2.(a) If veteran, name war: World War # 2.

3.(a) FULL NAME: William Edmund Noon.

3.(b) Social Security Number: 217-05-0278

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 15, 1905.

8. AGE: Years	Months	Days	If less than one day
39	11	23	hrs. min.

9. Birthplace: Westernport, Md. (Town, county, and state)
10. Usual occupation: None.
11. Industry or business

FATHER
12. Name: E. J. Noon.
13. Birthplace: Pa.

MOTHER
14. Maiden name: Mary E. Geoghegan
15. Birthplace: Piedmont, West Va.

16. Informant: Mrs. John Determan.
Address: 119 Church Street, Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12, 1945. (month) (day) (year)
Cemetery or crematory: St. Peters.
Location: Westernport, Md.
16. Funeral director: W. Harold Fredlock
Address: Piedmont, West Va.

19. Nov 14 1945 A. Kaye Baker M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8th 1945, at 9:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 '45 to Nov 8 1945
and that I last saw h[illegible] alive on Nov 8th 1945

Immediate cause of death	DURATION
Due to: Coronary Thrombosis	3 hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jesse H. Wilson M.D.
M. D. or other
Address: Piedmont W. Va. Date signed: 11/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10653

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Yrs.
Hospital, institution, or street address where death occurred:
17 So. Waverly Terrace
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 17 So. Waverly Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Anna Rebecca Northcraft

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Patrick H. Northcraft
Deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7, 1862

8. AGE: Years	Months	Days	If less than one day
83	7	21	hrs. min.

9. Birthplace: Black Valley, Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Gordon
13. Birthplace: Penna.

MOTHER
14. Maiden name: Rebecca Casteel
15. Birthplace: Penna.

16. Informant: Mrs George Gore
Address: 17 S. Waverly Terrace Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1945 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Nov. 1 1945 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 28, 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7, 1945, to Nov. 28 1945
and that I last saw h- alive on Nov. 27 1945

	DURATION
Immediate cause of death: Chronic interstitial nephritis Duration: 3 years	3 Days
Due to: Mastitis	1 Year
Due to: Infirmities of Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Thos H Gore M. D. or other
Address Cumberland Md Date signed 12-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

10654

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 3hrs 55 Min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Howard Place
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Barney Payne

3. (b) Social Security Number: 212-12-8926

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Eliza Payne

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): June 13 1878

8. AGE: Years	Months	Days	If less than one day
67	5	8	...hrs. ...min.

9. Birthplace: St. Louis, Mo.
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Carver High School

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Mrs. Eliza Payne

Address: Howard Place, Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 11/24/45
(month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov. 24, 1945
(Date rec'd by registrar)
Jos. L. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1945, at 12-35P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 21 1945, to Nov. 21 1945

and that I last saw him alive on 11/21 1945

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage	
Due to: Accidental by percolation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followiog:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Bring M.D.
M. D. or Other

Address: Evans Mad. Date signed: 11/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ba)

CERTIFICATE OF DEATH

10655

Reg. Dist. No. 2

1. PLACE OF DEATH:
County: Allegany
City or town: McCoole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: McCoole
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 136 Queen St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Matilda Agnes Pearce

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jas.T.Pearce
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 2, 1873

8. AGE: Years	Months	Days	If less than one day
72	0	16	..... hrs. ..... min.

9. Birthplace: W. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Wm. H. Snider
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Mary White
15. Birthplace: Scotland

16. Informant: Robt. E. Pearce
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/20/45 (month) (day) (year)
Cemetery or crematory: XXX Philos Cem.
Location: Westernport, Md.

18. Funeral director: B.W.Markwood
Address: Keyser, W.Va.

19. Nov. 20 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18, 1945 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-17 1945, to 11-18 1945 and that I last saw her alive on 11-18-45 1945

Immediate cause of death	DURATION
Myocarditis acute	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Jas A. Newcomer M. D. or other
Address: Keyser W.Va. Date signed 11-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

10656

Reg. Diat. No. [redacted] 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mo. Allegany County infirmary

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Barton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Susan Francis Pearce

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

B.(b) Name of husband or wife John F. Pearce

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1854

8. AGE:	Years	Months	Days	If less than one day
	90	10	29	..... hrs. ..... min.

9. Birthplace Barton - Allegany - Md.
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

FATHER 12. Name Jesse Mitchell

13. Birthplace Firmanck, Md.

MOTHER 14. Maiden name Nancy Fazenbaker

15. Birthplace Firmanck, Md.

16. Informant Norella Pearce Gray

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 2, 45 (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Moscow, Md.

18. Funeral director Edgworth & Beal

Address Westernport, Md.

19. Dec 1 (Date rec'd by registrar) 19 45 Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1945, to Nov 29 1945 and that I last saw h alive on 11-28-1945

Immediate cause of death	DURATION
Carcinoma	
Due to Of Stomach	One yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 11-30-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10657

★ Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two

Hospital, Institution, or street address where death occurred: 1014 Harding Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Allegany County: Allegany

City or town: Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 1014 Harding Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Susan Rooser Pirl

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Samuel Pirl

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 9 1878

8. AGE: Years	Months	Days	If less than one day
67	3	29	..... hrs. ..... min.

9. Birthplace: Lexington Penna (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Will R. King

FATHER — 13. Birthplace: Penna

MOTHER — 14. Maiden name: Missouri Rooser

MOTHER — 15. Birthplace: Penna

16. Informant: Mrs. Laura Humbertson

Address: 1014 Harding Ave. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/10/45 (month) (day) (year)

Cemetery or crematory: Narrowdale Cem.

Location: Lavenaville, Penna.

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md.

19. Nov. 10 1945 (Date rec'd by registrar) Hunter R. Trout, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8 1945, at 2 45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 27 1945 to November 8 1945 and that I last saw h...er alive on November 7 1945

Immediate cause of death	DURATION
Myocardial Infarction with Thrombosis	10 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. J. Solomon Jr. M.D. M. D. or other

Address: Cumberland, Md. Date signed 11-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10658 ★ Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, Institution, or street address where death occurred: Hodgson Maternity Clinic

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Constance Marie Porter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 21st 1945

8. AGE: Years | Months | Days | If less than one day: 1 hrs. min.

9. Birthplace: Lonaconing, Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER 12. Name: Fireman Joseph Porter

FATHER 13. Birthplace: Lonaconing, Md

MOTHER 14. Maiden name: Gladys Magdalene Muller

MOTHER 15. Birthplace: Beryl W. Va

16. Informant: Fireman Porter

Address: Lonaconing, Md

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Nov. 25 1945 (Date rec'd by registrar) D. E. Dan'l Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 1945, at 12 05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 21 1945, to Nov 22 1945 and that I last saw h.. alive on Nov 21 1945

Immediate cause of death	DURATION
Premature birth (5 months)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry Jos. Hodgson M.D. M. D. or other

Address: Lonaconing, Md Date signed: Nov 22 '45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15

10659

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Mines (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. Route No. 1 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ann Porter

3.(b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Morris M. T. Porter

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) May 7 - 1858

8. AGE: Years 87 Months 5 Days 12 If less than one day ... hrs. ... min.

9. Birthplace Eckhart Allegany, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Henry Rychanne

13. Birthplace Germany

MOTHER 14. Maiden name Mary Leidinger

15. Birthplace Don't know

16. Informant Mrs David Stark

Address 148 Maple St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-22-1945 (month) (day) (year)

Cemetery or crematory Porter's Cemetery

Location Eckhart Mines, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19 11-22 (Date rec'd by registrar) 1945 Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1945, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to Nov. 19 1945

and that I last saw her alive on Nov 19 1945

Immediate cause of death	DURATION
Carcinoma of stomach.	2 yrs.
Due to arterio-sclerosis.	
Due to Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations X Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D. M. D. or other

Address Frostburg, Md. Date signed 11/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 176

CERTIFICATE OF DEATH

10660

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Midland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles M. Preston

3.(b) Social Security Number 216-07-6249

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Isinour 6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 6, 1900

8. AGE: Years 45 Months 5 Days 11 If less than one day ... hrs. ... min.

9. Birthplace Bloomington, Md. (Town, county, and state)

10. Usual occupation Oiler

11. Industry or business Hardwood Construction Co.

FATHER 12. Name Mieshiak Preston

FATHER 13. Birthplace Barton, Md.

MOTHER 14. Maiden name Annie Crawford

MOTHER 15. Birthplace Barton, Md.

16. Informant Mrs. Mary Preston

Address Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20, 1945 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director D. J. Eichhorn

Address Lonaconing, Md.

19. 11-20 1945 Mrs Nancy N. Dye (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH November 17th, 1945 at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage; Shock	4 days
Due to Rupture both kidneys, fract. lower cervical ribs, posteriorly.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations as above

... Date of op. ...

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 11-13-45

Where did injury occur? Gilmore, Allegany, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) strip mine

Means of injury crushed by steam shovel Injured at work? yes

23. SIGNATURE Prince H. Brady, M.D. M. D. or other

Address Cumberland, Maryland. Date signed 11-17-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. WILSON

WITHIN CORPORATE LIMITS

10661

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (174)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County ALLEGANY
City or town TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME REALL, WALTER MR.

3.(b) Social Security Number 213-10-3718

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Married

6.(b) Name of husband or wife Veal Reall
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 19, 1905

8. AGE: Years 40 | Months 3 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Gormania, W. Va.
(Town, county, and state)
10. Usual occupation MINER
11. Industry or business STANLEY COAL CO.

FATHER
12. Name C. L. Reall
13. Birthplace Gormania, W. Va.

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Golden Funeral Home
Address Oakland, Md.
17. Buried Date thereof Nov. 15, 1945
(Burial, cremation, or removal? Which?) (month) (day) (year)
Cemetery or crematory Laurel Grove
Location Near Oakland, Md.
18. Funeral director Emroy Bolden
Address Oakland Md
19. Nov 13 1945 Winter L. Brant, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 8 19 45 at 5:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-30 19 45, to 11-8 19 45
and that I last saw h alive on 19

	DURATION
Immediate cause of death Pulmonary embolus	1 day
Due to Shock following	
Due to Crushing injury	9 day
Other conditions Fractured pelvis	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-30-45
Where did injury occur? Main and Oak (City or town) Oakland (County) Md (State)
Injured at home, farm, industry, public place (where?) Mine
Means of injury a 20 ton body rolled over on him Injured at work? Yes

23. SIGNATURE E. M. Wilson M.D.
M. D. or other
Address Cumberland Md Date signed 11-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10662

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 10. Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 512. Hill Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Victor Richardson

3. (b) Social Security Number

212-12-8843

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6 1919

8. AGE: Years	Months	Days	If less than one day
26	6	23	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: Kline Furniture Co

FATHER
12. Name: Eugene Dorsey
13. Birthplace: Unknown

MOTHER
14. Maiden name: Lenora Richardson
15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Lenora Richardson
Address: 512. Hill St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec. 1 19 45 Joseph A Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 19 45 at 11-03 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25 19 45 to Nov. 29 19 45

and that I last saw him alive on November 29 19 45

Immediate cause of death	DURATION
Lobar Pneumonia (Left)	10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Blanche M. Schindler M.D.
M. D. or other

Address: 41 Greene St Date signed: Nov 30 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-9

CERTIFICATE OF DEATH

10663

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME RILEY, BABY BOY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

8.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 22, 1945

8. AGE: Years	Months	Days	If less than one day
		3	hrs. min.

9. Birthplace OAKLAND, MARYLAND (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name CARLOS L. RILEY

13. Birthplace MD.

MOTHER 14. Maiden name HARRIETT MARTIN

15. Birthplace NORTH CAROLINA

18. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD

17. Buried (Burial, cremation, or removal. What?) Date then to Nov. 26, 1945 (month) (day) (year)

Cemetery or crematory White Cem

Location Lock Lynn, Md.

18. Funeral director Emroy Bolden

Address Oakland Md.

19. Nov. 26, 1945 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 1945 to Nov 22 1945

and that I last saw h— alive on Nov 22 1945

Immediate cause of death	DURATION
a. Tentonetes	
b.	
Due to, or as a consequence of: a. Penetration Intestinal Canal - Thought moved	
b.	
Due to, or as a consequence of: a.	
b.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Grace M. D. or other

Address Cumberland Md Date signed Nov 26 45

10664

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bal.)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Cresaptown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cresaptown (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Catherine Elvira Rawe

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Frederick Rawe
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): April 2 1860
8. AGE: Years: 85 Months: 7 Days: 11 If less than one day: hrs. min.
9. Birthplace: Loraconing, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: Samuel Miller
FATHER 13. Birthplace: Loraconing, Md.
MOTHER 14. Maiden name: Charlotte Miller
MOTHER 15. Birthplace: Near Loraconing, Md.
16. Informant: Mrs. George Brannon
Address: Barton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: W. E. Litchhorn
Address: Loraconing, Md.
19. November 14 1945 (Date rec'd by registrar) Dr. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1945, at 4:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945, to Nov 13 1945
and that I last saw h... alive on Nov. 10 1945

Immediate cause of death — DURATION
Arteriosclerosis — 1 mo
Chronic Myocarditis — 1 mo
Due to: —
Due to: —
Other conditions: Senility
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: Norman Reese M.D. M. D. or other
Address: Westernport, Md. Date signed: 11-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

10665

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:
23 Arch St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: Beaver

City or town: Ambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. 274 Marshall St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Russell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 2, 1944

8. AGE:

Years	Months	Days	If less than one day
0	11	5	..... hrs. ..... min.

9. Birthplace: Ambridge, Pa.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: David Russell
13. Birthplace: Pittsburgh, Pa.

MOTHER
14. Maiden name: Mary L. Flook
15. Birthplace: Cumberland, Md

16. Informant: Mrs. Rose Walsh

Address: 23 Arch St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 10, 1945 (month) (day) (year)

Cemetery or crematory: Economy Cemetary

Location: Beaver Co., Pa.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Nov. 8, 1945 (Date rec'd by registrar) Winter R. Tranter, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7, 1945, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 7, 1945, to Nov. 7, 1945 and that I last saw him alive on Nov. 7, 1945.

	DURATION
Immediate cause of death: Pneumonia	3 da.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: L. J. Lanich, M.D. M. D. or other

Address: Cumberland, Md. Date signed: 11-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-A)

CERTIFICATE OF DEATH

10666

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Near Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. # 5 --- Box 398
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ~~Mrs. Alice Seelbach~~ Mrs. Amanda Alice Seelbach

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Theodore Seelbach
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 12, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	19	..... hrs. ..... min.

9. Birthplace Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name ~~Dedd~~ Joseph Ford
13. Birthplace Rockingham Co. Va
MOTHER 14. Maiden name ~~Dedd~~ Amanda Howard
15. Birthplace Rockingham Co. Va.
16. Informant Mrs. Leila Fabrizio
Address Box 398 Rt #5, Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1945 (month) (day) (year)
Cemetery or crematory Mennonite Cemetery
Location Pinto, Md.
18. Funeral director John F. Hoffman
Address Cumberland, Md.
19. Nov. 3, 1945 (Date rec'd by registrar) Winter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1945 at 5:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17, 1945, to Nov. 1, 1945 and that I last saw her alive on Nov. 1, 1945
Immediate cause of death Cerebral Concussion and Subdural Hemorrhage accident. I'd — DURATION 10 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Oct 17, 1945
Where did injury occur? Near Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury Fall. Injured at work? No

23. SIGNATURE O. F. Wilson M.D. M. D. or other
Address Cumberland Md. Date signed 11-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10667

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 minutes
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD #1 Box 79
(If rural, give LOCATION)
2.(o) If veteran, name war:

3. (a) FULL NAME: Baby Girl Shumaker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 7, 1945

8. AGE: Years | Months | Days | If less than one day: hrs. 15 min.

9. Birthplace: Frostburg Md
(Town, county and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William Benson Shumaker
13. Birthplace: Myersdale, Pa

MOTHER
14. Maiden name: Mabel Morgan
15. Birthplace: Shaft, Md

16. Informant: Mrs. Shumaker
Address: RFD #1, Frostburg

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: 11-8-1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.

18. Funeral director: Daniel D. Kelly
Address: Frostburg, Md.

19. 11-8 1945 Mrs. Daisy H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 1945, at 4 oz P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11/7 1945, to 11/7 1945
and that I last saw h.. alive on 11/7 1945

Immediate cause of death	DURATION
Asian cephalic monster	
Due to	
Due to	
Other conditions: Prematurity	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jourdet Kelly Md
M.D. or other
Address: Frostburg, Md. Date signed: 11/9/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

10668

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55. Years

Hospital, institution, or street address where death occurred:
26. Oak Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 26. Oak Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Minnie Sibley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles J. Sibley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 24, 1864

8. AGE: Years	Months	Days	If less than one day
81	1	13	..... hrs. ..... min.

9. Birthplace: Mainsburg, Bedford Co, Penna
(Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER
12. Name: Unknown
13. Birthplace: Bedford Co, Penna.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Bedford Co, Penna.

16. Informant: Mrs. Vernon Loy

Address: 622. Frederick St. Cumberland, Md.

17. Burial (Bnrial, cremation, or removal. Which?) Date thereof 11/11/45 (month) (day) (year)

Cemetery or crematory: St. Lukes Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov 9 1945 (Date rec'd by registrar) Winter R. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7, 1945 to Nov. 7, 1945 and that I last saw her alive on Nov. 7, 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	5 yrs.
Due to: Chronic Myocarditis	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay E. Simms M. D. or other

Address: Cumberland Date signed: Nov. 8, 1945.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10669

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs.
Hospital, institution, or street address where death occurred: Green St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Ellen Springer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James D. Springer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 2, 1849

8. AGE:	Years	Months	Days	If less than one day
	96	9	4	hrs. min.

9. Birthplace: Fairmont-Marion-W.Va. (Town, county, and state)
10. Usual occupation: House-work
11. Industry or business

FATHER
12. Name: Felix Barker
13. Birthplace: Not known

MOTHER
14. Maiden name: Cassandra Griffith
15. Birthplace: Clarksburg, W.Va.

16. Informant: Mrs. E.E. Springer
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 9, 45 (month) (day) (year)
Cemetery or crematory: Philos Cem.
Location: Westernport, Md.
18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. Nov. 8 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 6 19 45 at 9.30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 19 45, to Nov. 6 19 45
and that I last saw h.C.V. alive on Nov. 6 19 45

	DURATION
Immediate cause of death: Myocarditis	2 wks
Due to: Arteriosclerosis	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E E Berry MD
Address: Fairmont W. Va. M. D. or other
Date signed: 11/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

10670

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Lynchburg Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hours
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Bedford
City or town: Buffalo Mills (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Walter Summers

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nora Heidorn

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 22, 1892

8. AGE: Years	Months	Days	If less than one day
53	1	29	..... hrs. ..... min.

9. Birthplace: England (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Own Business

FATHER
12. Name: unknown
13. Birthplace: —

MOTHER
14. Maiden name: unknown
15. Birthplace: —

16. Informant: Mrs. Nora Summers
Address: Buffalo Mills, RD1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25 1945 (month) (day) (year)
Cemetery or crematory: Richland
Location: Johnstown
18. Funeral director: C. F. Leigler
Address: Hyndman, Pa.

19. Nov. 24 1945 (Date rec'd by registrar) Jno. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21 1945 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1945 to Nov 21 1945 and that I last saw him alive on Nov. 21 1945

Immediate cause of death	DURATION
Traumatic Shock	2 5 hrs
Due to: Head Injury, accident	
to auto accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of Nov 20, 1945
Where did injury occur? Hyndman (City or town) Bedford (County) Pa. (State)
Injured at home, farm, industry, public place (where?) Highway Route #96
Means of injury auto accident Injured at work? No.

23. SIGNATURE: John C Topper M.D. (M. D. or other)
Address: Hyndman Pa Date signed 11/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

10671

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (Ward) (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or ~~street address~~ where death occurred: Sylvan Retreat
How long in hospital or institution? 16 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)
State: Maryland County: Allegany
City or town: Ft. Lonsdale - Near Frostburg (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ellen Blackwell Truly

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Nov. 6th, 1877

8. AGE: Years: 68 | Months: 0 | Days: 0 | If less than one day: hrs. min.

8. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER — 12. Name: William Truly
FATHER — 13. Birthplace: Canada
MOTHER — 14. Maiden name: Margaret Graham
MOTHER — 15. Birthplace: Unknown
16. Informant: Mrs. Frank Truly
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: M. J. Eichhorn
Address: Lonaconing, Md.
19. Nov. 8, 1945 (Date rec'd by registrar) Winter K. Brant, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-6-1945 at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 31 1938 to 11-6-1945 and that I last saw her alive on 11-4-1945

Immediate cause of death	DURATION
Chronic Myocardial Degeneration	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 11-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside of City Limits

(W) Grove

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

10672

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: North Branch.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. North Branch.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Catherine Twigg

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wm Twigg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 10 1868

8. AGE:	Years	Months	Days	If less than one day
	77	6	1	..... hrs. ..... min.

9. Birthplace Pennsylvania

(Town, county, and State)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Henry Leighty

13. Birthplace Pa.

MOTHER 14. Maiden name Rebecca Desmond

15. Birthplace Pa.

16. Informant Wm Twigg

Address North Branch, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-14-45 (month) (day) (year)

Cemetery or crematory Evans Memorial Cem

Location Old town Rd.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Nov 13 1945 Walter R. Frantz M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1943 to Nov 11, 1945 and that I last saw h[illegible] alive on Nov 8, 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 yrs.
Due to Hypertension	
cardio - vascular disease	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. R. Frantz M.D. M. D. or other

Address Medical Bldg Date signed 11-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

10673

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, Institution, or street address where death occurred:
407 Central Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 407 Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Orlena Twigg

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Levin Twigg
Deceased (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 24, 1853

8. AGE: Years	Months	Days	If less than one day
92	2	26	..... hrs. ..... min.

9. Birthplace: Oldtown, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Richard Nicely
13. Birthplace: Maryland

MOTHER 14. Maiden name: Rebecca ?
15. Birthplace: Maryland

16. Informant: Mrs. Julia Leasure
Address: 407 Central Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 22, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Taber Cemetery
Location: Oldtown Rd. near Cumberland

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Nov 21, 1945 (Date rec'd by registrar) Jos. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19, 1945, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943, to Nov. 19 1945
and that I last saw h[illegible] alive on Nov. 10 1945
Immediate cause of death: Cerebral Hemorrhage
Cerebral Coma, 2 days — DURATION: 3 yrs.
Due to: Influenza Pneumonia 7 days
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos H Rowe M. D. or other
Address: Cumberland Md Date signed: Nov 21 1945

WITHIN CORPORATE LIMITS

Evidence for the change of age is shown on G 99 12- 7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (949)

CERTIFICATE OF DEATH

10674

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address, where death occurred:
Rear 507 Dilley St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rear 507 Dilley St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Theodore Raymond Valentine

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 28, 1904

8. AGE: Years	Months	Days	If less than one day
41 40	7	28	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Charles L. Valentine
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lillie Welsh
15. Birthplace: Maryland

16. Informant: Mrs. Lillie Valentine
Address: Rear 507 Dilley St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 28, 1945 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cem.

Location: Bedford Road

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Nov. 27 19 45 Joseph P. Franklin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25th., 19 45, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions: History of Grippe for several days. (Include pregnancy within 3 months of death)	

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Pierce H. Bowen, M.D.
M. D. or other

Address: Cumberland, Maryland. Date signed: 11-25-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

10675

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give neareat town)
Street No. WASHINGTON LEE APTS.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MR. CHARLES, G. WATSON

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

8.(b) Name of husband or wife Catherine Rouse Watson
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 16, 1866

8. AGE: Years	Months	Days	If less than one day
79	5	21	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation ATTORNEY
11. Industry or business
FATHER 12. Name JOHN D. WATSON
13. Birthplace MARYLAND
MOTHER 14. Maiden name MARY MCGINNIS
15. Birthplace MARYLAND
16. Informant MEMORIAL HSOPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1945 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.
18. Funeral director Charles L. George
Address Cumberland, Md.
19. Nov 7 1945 Hunter A. Dority Mgt Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 6 1945 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3 1945 to Nov 6 1945 and that I last saw him alive on Nov. 5 1945

Immediate cause of death	DURATION
Uremia	6 days
Coronary Artery Disease	?
Due to Myocardial Disease	?
Due to Pneumonia, Hypostatic & Lobular	6 days
Other conditions Chronic Diffuse Glomerulonephritis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Jamison M.D.
M. D. or other
Address 15 E. Loth St. Date signed 11/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9321

10676

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, Institution, or street address where death occurred: 109 Race St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Earl Fitz Weaver

3.(b) Social Security Number 705-09-9891

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 11 1881

8. AGE: Years	Months	Days	If less than one day
64	7	26	....hrs. ....min.

9. Birthplace Martinsburg W. Va. (Town, county, and state)

10. Usual occupation Tool Insp.

11. Industry or business B & O Ry.

MOTHER FATHER

12. Name John J Weaver

13. Birthplace W. Va

14. Maiden name Mary M Giles

15. Birthplace W. Va

16. Informant Mrs Mary M Moore

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-9-45 (month) (day) (year)

Cemetery or crematory Rolleresh Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Nov. 8 19 45 Hunter R. Frantz Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1945 at 4 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 1945 to Nov. 7, 1945

and that I last saw him alive on Nov. 1, 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	5 yrs
Due to Myocarditis	2 yrs
Due to Uraemia	4 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clark L Turner M. D. or other

Address Cumberland Date signed Nov. 7, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

Dorrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49

CERTIFICATE OF DEATH

10677

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

436 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 436 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Mrs Samuel Morgan White

3.(b) Social Security Number 705-09-9806

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

8.(b) Name of husband or wife Delores Ernest

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1888

8. AGE:	Years	Months	Days	If less than one day
	57	1	19	..... hrs. ..... min.

9. Birthplace Grafton, Taylor Co. W. Va. (Town, county, and state)

10. Usual occupation Boiler Maker, Helper

11. Industry or business B & O. Railroad.

FATHER 12. Name Alfred M. White

13. Birthplace Marion Co. W. Va.

MOTHER 14. Maiden name Margaret J. Wood

15. Birthplace Marion Co. W. Va.

16. Informant Melville White

Address 436 Seymour St. Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland Md

19. Nov. 29 19 45 Jos. P. Franklin M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 19 45 at 7:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 19 45 to Nov. 27 19 45

and that I last saw h-- alive on Nov. 26, 19 45

Immediate cause of death	DURATION
Carcinoma Pancreas	6 mon.
Due to Abdominal Carcinomatosis	4 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Abdominal Carcinomatosis Date of op. Nov. 5, 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clay F. Turner M. D. or other

Address Cumberland Date signed Nov. 29, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Diat. No. 10678

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 82 yrs.
Hospital, Institution, or street address where death occurred:
Barton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Ellsworth Williams

3. (b) Social Security Number: 212-12-8358

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Minnie C.
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1863

8. AGE:

Years	Months	Days	If less than one day
81	11	28	hrs. min.

9. Birthplace: Barton, Allegany, Md.
(Town, county, and state)
10. Usual occupation: Retired Merchant
11. Industry or business:
FATHER 12. Name: Geo E. Williams
13. Birthplace: Edinburgh, Scotland
MOTHER 14. Maiden name: Janet Shearer
15. Birthplace: Edinburgh, Scotland.
16. Informant: Hettie J. Otto
Address: Hazelthorpe, Md.
17. Burial, cremation, or removal. Which? Burial. Date thereof Nov 6-1945 (month) (day) (year)
Cemetery or crematory: Laurel Hill
Location: Mapleoak, Md.
18. Funeral director: Boal's Funeral Director
Address: Westernport, Md.
19. (Date rec'd by registrar) 19 — Registrar: L. A. Boucher

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 4 1945, at 4 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1945, to Nov 3 1945, and that I last saw him alive on Nov 3 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions: Probably Cancer of Stomach	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. A. Boucher M. D. or other
Address: Barton, Date signed Nov. 4-1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10679

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany Co.

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo 27 da

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany Co.

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Carroll St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Donald W. Wolfhope

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): September 22, 1945

8. AGE: Years	Months	Days	If less than one day
~~1~~	1	27	____ hrs. ____ min.

9. Birthplace: Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: John Wolfhope
13. Birthplace: Maryland

MOTHER
14. Maiden name: Evelyn Martz
15. Birthplace: Maryland

16. Informant: Mrs Frank A. Wolfhope
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 21 1945 (month) (day) (year)

Cemetery or crematory: St P. & P. Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. Nov. 20, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 19 45, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-18 19 45, to 11-19 19 45 and that I last saw him alive on 11-19 19 45

Immediate cause of death	DURATION
Lobar Pneumonia	2 dys
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: Lobar Pneumonia, staph

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. J. Johnson Jr. M.D. or other

Address: [illegible] Date signed: 11-19-45